STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145661	A. Building B. Wing	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ryze West	5130 West Jackson Boulevard Chicago, IL 60644

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 32819 Based upon observation, interview and record review the facility failed to ensure that call lights were within reach for three of four residents (R4, R5, R6) reviewed for falls. Findings include; R4's diagnoses include malaise. R4's (11/19/21) BIMS (Brief Interview of Mental Status) determined a score of 11 (moderate impairment). The (11/19/21) functional assessment affirms R4 requires one (1) person physical assist with bed mobility and transfers. R4's (3/26/19) care plan includes poor safety awareness and weakness, intervention: call light within resident's reach when in room. On 1/10/22 at 2:51pm, R4 was lying in bed. Surveyor inquired about the location of the call light R4 responded It's probably lying on the floor. R4 subsequently searched for the call light and stated it's on the floor behind the bed. R4 was able to reach the call light cord however the button was stuck beneath the bed frame and the wall therefore unable to use it. R5's diagnoses include age related debility. R5's (12/16/21) BIMS determined a score of 13 (cognitively intact). The (12/16/21) functional assessment affirms R5 requires extensive assistance with bed mobility, transfer and toilet use. R5's (7/27/21) care plan includes; actual fall, intervention: place call light within reach. On 1/10/22 at 3:00pm, R5 was lying in bed. Surveyor inquired where R5's call light was located R5 responded It's over on her (referring to roommate) side on the floor. R5's call light was subsequently observed under R5's roommate's bed, on the floor and out of reach. On 1/10/22 at 3:08pm, surveyor inquired about the location or R5's call light V9 (LPN/Licensed Practical Nurse) stated It looks like it's up under here and pointed below R5's roommate's bed. Surveyor inquired if the call light was within reach V9 responded Not at the moment. Surveyor inquired where the call light should be located V9 replied Within reach. R6's diagnoses include hemiplegia and hemiparesis. R6's (11/30/21) BIMS determined a score of 13 (cognitively intact). The (11/30/21) functional assessment affirms R6 requires extensive assistance with bed mobility, transfers and toilet use. R6's (2/10/16) care plan states resident has potential for falls, intervention: call light within resident's reach when in room. On 1/10/22 at 3:05pm, R6 was observed lying in bed. Surveyor inquired about the location of R6's call light R6 stated It's over here somewhere, can you reach it for me. R6's call light was behind the head of bed, on the floor and out of reach. Surveyor inquired if R6 is able to walk R6 responded No. On 1/10/22 at 3:12pm surveyor inquired about the location of R6's call light V9 (LPN) stated It's behind the bed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The call light answering policy (revised 01/22) states when the resident is in bed or confined to bed or chair, provide the call light within easy reach of the patient or resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32819 Based upon record review and interview the facility failed to ensure that staff are aware of resident assignments, failed to follow physician orders by not monitoring vital signs every 4 hours, and failed to address resident change in condition for one of nine residents (R1) reviewed for infection control. These failures resulted in R1's not being monitored as ordered by physican and ([DATE]) death. Findings include; R1 was [AGE] years old. The ([DATE]) progress notes state R1's ([DATE]) Covid test result was positive. R1's ([DATE]) POS (Physician Order Sheets) state monitor patient with Covid 19 diagnosis or suspected Covid 19 for signs of clinical deterioration, such as rapidly progressive respiratory failure and sepsis. Monitor vital signs (full vitals) every 4 hours for 14 days. Observe for evidence of deterioration. Call medical doctor/nurse practitioner as indicated. On [DATE] at 2:14pm, R10 (R1's roommate) stated on New Year's eve (2021) and New Year's day (2022) the Nurse said she was the only nurse on the floor, cause of the Covid a lot of nurses called off. Surveyor inquired about R1's status on or about [DATE] R10 responded I (R10) used to help him (R1) go out and smoke but when they (staff) moved him (R1) in the room ([DATE]) I didn't even recognize him (R1). When he (R1) talked you couldn't even hear him he (R1) talked so soft. His (R1's) face was grey, he looked like his skin sunk in like bones and everything. They should have sent him (R1) to the hospital. Every time he (R1) would call the Nurses they would come in, turn his light off and go away. He couldn't talk and tell em what he needed. The day before he died ([DATE]) she (Nurse) didn't even come in the room for vital signs or meds our door was closed all night. The next day I (R10) called the nurse, told her something was wrong with him and he was dead. R10's ([DATE]) BIMS (Brief Interview of Mental Status) determined a score of 15 (cognitively intact). R1's ([DATE]) Certificate of Death states death occurred in a nursing home. Cause of Death Novel Corona (Covid 19) Viral Infection. Time of Death: 9:03am. The ([DATE]/[DATE]) MARS (Medication Administration Records) affirm that R1's vital signs were last documented on [DATE] at 3:00pm therefore on [DATE] (7:00pm & 11:00pm) and [DATE] (3:00am & 7:00am) vital signs were not documented. R1's vitals summary affirms no additional vital signs were documented on or about aforementioned dates as stated. [R2's Covid 19 monitoring evaluations for [DATE] and [DATE] were entered by V2 (DON/Director of Nursing) on [DATE], approximately a week after he expired]. R1's progress notes state; ([DATE]) 8:36am, Upon making morning rounds writer observed resident unresponsive, pupils dilated, no pulse palpated and no vital signs obtained. No response to verbal or tactile stimuli. CPR (Cardiopulmonary Resuscitation) initiated. 911 called. Paramedics in facility take over CPR. Resident still no vital signs at this time. Paramedics informed writer resident has expired. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 11:19am, surveyor inquired about R1's ([DATE]) 7am-3pm status V9 (Licensed Practical Nurse) stated Upon coming onto shift I was doing my rounds and I found him unresponsive. He was laying on his stomach, he was cold and his eyes was fixed. I checked for vital signs there were none so I called a code blue and initiated CPR (Cardiopulmonary Resuscitation). Surveyor inquired why R1's 7:00am vital signs were not obtained V9 responded I started at like 8:30 cause they was short a nurse so they asked me to come in. On [DATE] at 11:42am, surveyor inquired about the facility protocol for residents who acquired Covid 19. V2 (DON) stated, We put in orders for vital signs and the monitoring. Surveyor inquired where vital signs are documented V2 responded, They're documented on the MAR (Medication Administration Record) they're also documented in the monitoring tool for like a change in condition. It's under forms, Covid monitoring. Surveyor inquired about the required frequency for Covid monitoring V2 replied Everyone (re: Covid positive residents) should be having it (referring to the electronic Covid 19 monitoring evaluation) every shift. V2 subsequently accessed R1's electronic Covid 19 Monitoring Evaluations and affirmed that she (V2) entered the ([DATE], [DATE], [DATE]) 7am-3pm assessments however additional assessments (for other shifts) were not documented. Upon further inspection all aforementioned assessments were entered on [DATE] (a week later). On [DATE] at 10:02am, surveyor inquired about R1's ([DATE]) status on the 11pm-7am shift V13 (Registered Nurse) stated I was assigned to rooms ,d+[DATE] he (R1) was assigned to someone else. Surveyor inquired which nurse R1 was assigned to V13 responded I don't remember. R1 resided on the 2nd floor. On [DATE] at 10:16am, V2 presented the 2nd floor ([DATE]) 11pm-7am daily assignment sheet (as requested) which states V13 was assigned to rooms ,d+[DATE]. Surveyor inquired if V13 was assigned to the entire 2nd floor on [DATE] (11pm-7am) V2 stated Yes. Surveyor advised that V13 stated he was not assigned to R1 on [DATE], therefore R1's assessments were not documented on or about said date/time, and R1's vital signs were not documented for 16 hours (prior to his death) which were supposed to be monitored every 4 hours. V2 responded I know he told you that but he was the nurse assigned for that night. On [DATE] at 3:00pm, surveyor inquired about potential harm to a Covid 19 positive resident if not monitored for change in condition and/or vital signs are not obtained as ordered. V14 (Medical Director) responded, If the vital signs are all stable and the condition is the same than not reporting to the Physician wouldn't cause any harm but not reporting to the Physician that the condition is different or the vital signs have changed than the implications may be different depending on the circumstance. Change in condition can be anything it would depend on what the vitals was. Not having vitals is not good, we should have the vitals to make sure they are stable. We can only assess the viability if they (vital signs) are stable. The coronavirus 2019 policy (revised [DATE]) states if patients have been screened and their testing is positive for Covid 19: cohort with another symptomatic/positive patient. Vitals (temperature, heart rate, respirations) and pulse oximetry every 4 hours. Blood pressure every 8 hours. The change in resident's condition (reviewed ,d+[DATE]) states nursing will notify the resident's physician or nurse practitioner when: there is a significant change in the resident's physical, mental or emotional status. It is deemed necessary or appropriate in the best interest of the resident. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The coronavirus 2019 policy (revised [DATE]) states if patients have been screened and their testing is positive for Covid 19: cohort with another symptomatic/positive patient. Vitals (temperature, heart rate, respirations) and pulse oximetry every 4 hours. Blood pressure every 8 hours.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32819 Based upon observation, interview and record review the facility failed to ensure that sufficient nursing staff were available to meet the needs for eight of eight residents (R1, R3, R4, R5, R6, R7, R8, R9) reviewed for infection control. Findings include; On 1/10/22 at approximately 1:00pm, surveyor inquired if any residents in the facility are Covid positive V1 (Administrator) affirmed there was a recent Covid outbreak that affected 2nd, 3rd and 4th floor residents which are currently positive. On 1/10/22 at 2:01pm, surveyor inquired about the current 4th floor (7am-3pm) staffing V5 (CNA/Certified Nursing Assistant) stated We got 4 CNA's and 2 Nurses. We used to have 5 CNA's but lately it's been 4 and 3 now. It's really all shifts getting short. The (1/10/22) log of current Covid positive residents includes rooms [ROOM NUMBERS] however there were no contact/droplet precaution signs posted on and/or near either door. Surveyor inquired if the residents in room [ROOM NUMBER] and/or 430 were Covid positive V5 responded No, nobody told me they was isolation. On 1/10/22 at 2:10pm, R7 was observed ambulating throughout the 4th floor hallway without wearing a mask. Surveyor inquired why R7 was in the hallway without a mask on V5 (CNA) stated He just walked outta his room and he ain't gonna put it on anyway. When somebody ask him, he say no and provided no redirection and/or mask to R7. R8 subsequently exited the elevator with V7 (LPN/Licensed Practical Nurse) however R8's mask was on her chin. Surveyor inquired about the location of R8's mask V7 stated We encourage them (residents) as much as possible to keep em on and provided no redirection to R8. R9 was subsequently observed in the hallway without wearing a mask. Surveyor inquired why R9 was in the hallway without a mask on V8 (LPN) stated She's had one on 4 times. She keeps taking it off, that's what she does and provided no redirection and/or mask to R9. On 1/10/22 at 2:26pm, 3 residents were observed in the 4th floor dining room not wearing masks. Surveyor inquired about infection control concerns with the residents currently in the dining room V4 (Infection Control Nurse) stated They're not masked. Surveyor inquired about required PPE (Personal Protective Equipment) for residents while not in their rooms V4 responded They need to keep their mask on but nobody up here is going to keep their mask on. Surveyor inquired why none of the 3 residents (currently in the dining room) have a mask available V4 replied We constantly offer them masks however masks were not provided to said residents at this time. On 1/10/22 at 2:36pm, surveyor inquired about the current 3rd floor staffing V10 (LPN) stated We have 1 Nurse and I think 4 CNA's. We have 1 Nurse sometimes. Surveyor inquired why only 1 Nurse was present if 2 were assigned on today's date V10 responded I'm not sure what happened, you'll have to ask the scheduler. V10 affirmed she was assigned to 50 residents. Surveyor inquired how many 3rd floor residents are on isolation V10 responded We have several Covid cases every day, so there's 26. Surveyor inquired if the current 3rd staffing was adequate considering the acuity of the residents and donning/doffing PPE V10 replied We usually have 4 or 5 CNA's, they (Administration) told us our census was low. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/10/22 at 2:44pm, surveyor inquired about the current 2nd floor staffing V9 (LPN) stated We have 2 Nurses and 4 CNA's. [The 1/10/22 log of current Covid positive residents includes 12 (2nd floor) rooms]. R4 resides on 2nd floor. On 1/10/22 at 2:51pm, surveyor inquired about staffing concerns R4 stated It all depends on if I can get to my control and hit the button (referring to the call light). Surveyor inquired about the location of the call light R4 responded It's probably lying on the floor. R4 searched for the call light and stated it's on the floor behind the bed. R4 was able to reach the call light cord however the button was stuck beneath the bed frame and the wall therefore unable to use it. Surveyor inquired if facility staffing was adequate R4 replied They've (Facility Staff) been short some people for a week or so. R5 resides on 2nd floor. On 1/10/22 at 3:00pm, R5 was observed lying sideways in the bed with her legs dangling over the edge. Surveyor inquired if R5 was able to walk R5 stated No. Surveyor inquired if staff provide transfer assistance when she needs it R5 replied Not really, every time they always say I can help myself. Surveyor inquired if R5 was able to transfer herself to the wheelchair R5 stated Sometimes but not all the time. Surveyor inquired where R5's call light was located R5 responded It's over on her (referring to roommate) side on the floor. R5's call light was observed under R5's roommate's bed, on the floor and out of reach. On 1/10/22 at 3:08pm, surveyor inquired about the location or R5's call light V9 (LPN) stated It looks like it's up under here and pointed below R5's roommate's bed. Surveyor inquired if the call light was within reach V9 responded Not at the moment. Surveyor inquired where the call light should be located V9 replied Within reach. R6 resides on 2nd floor. On 1/10/22 at 3:05pm, R6 was observed lying in bed. Surveyor inquired about the location of R6's call light R6 stated It's over here somewhere, can you reach it for me. R6's call light was behind the head of bed, on the floor and out of reach. Surveyor inquired if R6 is able to walk R6 responded No. On 1/10/22 at 3:12pm surveyor inquired about the location of R6's call light V9 (LPN) stated It's behind the bed. On 1/18/22 at 11:42am, surveyor inquired about the facility protocol for residents who acquired Covid 19 V2 (DON/Director of Nursing) stated We put in orders for vital signs and the monitoring. Surveyor inquired where vital signs are documented V2 responded They're documented on the MAR (Medication Administration Record) they're also documented in the monitoring tool for like a change in condition. It's under forms, Covid monitoring. Surveyor inquired about the required frequency for Covid monitoring V2 replied Everyone (re: Covid positive residents) should be having it (referring to the electronic Covid 19 monitoring evaluation) every shift. V2 subsequently accessed R1's electronic Covid 19 Monitoring Evaluations and affirmed that she (V2) entered the (12/30/21, 12/31/21, 1/1/22) 7am-3pm assessments however additional assessments (for other shifts) were not documented. Surveyor inquired why V2 entered R1's assessments V2 stated We had a lot of staff out so we had to help out. R1, R3, R4, R5 and R6's (December 2021 and/or January 2022) physician orders include vital signs every 4 hours for 14 days (due to Covid 19 diagnosis) however the (December 2021 and/or January 2022) MAR affirms vital signs for aforementioned residents were not documented as ordered. R1, R3, R4, R5 and R6's (December 2021 and/or January2022) physician orders include monitoring for signs of clinical deterioration, such as rapidly progressive respiratory failure and sepsis every 8 hours however the Covid 19 monitoring evaluations affirm that aforementioned residents were not assessed as ordered. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The staffing policy (reviewed 12/2021) states staffing is based on the IDPH (Illinois Department of Public Health) formula for determining numbers and levels of staff. Staffing is then increased based on the needs of the resident population.

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F 0880 Level of Harm - Actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32819 1. Based upon observation, interview and record review the facility failed to follow and maintain infection prevention and control by providing a safe and sanitary environment to prevent the spread of infecion specifically Covid-19. These failures resulted in a Covid 19 outbreak throughout the facility on or about [DATE] which affected 166 residents and 51 staff that tested positive for Covid 19, and resulted in R3 who was Covid negative being cohorted with a known Covid positive and R3 becoming Covid positive. Findings include; The ([DATE]) census includes 187 residents. The census affirms that R3 has resided in current room since [DATE]. R4 was moved to R3's room on [DATE] [2 days after confirmed Covid 19 infection]. The Covid 19 resident tracking affirms R3 sustained covid acquired in facility date of symptom onset [DATE] [4 days after aforementioned room change]. R3's ([DATE]) POS (Physician Order Sheets) state monitor patient with Covid 19 diagnosis or suspected Covid 19 for signs of clinical deterioration, such as rapidly progressive respiratory failure and sepsis for 14 days. If positive call MD (Medical Doctor/NP (Nurse Practitioner). Monitor vital signs (full vitals) every 4 hours for 14 days. Observe for evidence of deterioration. Call MD/NP as indicated. R3's vitals summary affirms vital signs were obtained on [DATE] at 3:24pm however they were not documented on [DATE] (7pm and 11pm) and on [DATE] (3am, 7am, and 11am) as ordered therefore roughly 23 hours transpired without an assessment. R3's ([DATE]) 2:08pm progress notes state upon entering the room resident observed wheezing stating I can't breathe. Writer applied oxygen 2 liters per nasal cannula, saturation 87%. Nurse Practitioner called gave order to send resident out 911. Resident admitted for hypoxia related to Covid positive and sinus bradycardia (R3's pulse was 52 at 2pm per vitals summary). On [DATE] at approximately 1:00pm, surveyor inquired if any residents in the facility are Covid positive V1 (Administrator) affirmed there was a recent Covid outbreak that affected 2nd, 3rd and 4th floor residents which are currently positive. Surveyor inquired about the required PPE (Personal Protective Equipment) for staff V1 stated N95 and the face shields. Full PPE; gloves, gown and N95 if we go into the rooms. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 2:01pm, V5 (CNA/Certified Nursing Assistant) was observed in the 4th floor hallway wearing 2 surgical masks. Surveyor inquired why an N95 mask was not in use V5 stated I sometimes feel like I can't breathe with that one on so I just put 2 masks on. Surveyor inquired if V5 was mask fit tested V5 responded I didn't get fitted yet. I missed my day to get it fit so I guess they'll do em again. The ([DATE]) log of current Covid positive residents includes rooms [ROOM NUMBERS] however there were no contact/droplet precaution signs posted on and/or near either door. Surveyor inquired if the residents in room [ROOM NUMBER] and/or 430 were Covid positive V5 responded No, nobody told me they was isolation. On [DATE] at 2:07pm, V6 (CNA) was observed in the 4th floor hallway wearing 2 surgical masks. Surveyor inquired which masks she (V6) was wearing V6 stated The regular mask. Surveyor inquired which mask she (V6) was required to wear due to Covid outbreak throughout the facility V6 responded I know we supposed to have the N95. I can't breathe with it on. I have 2 of the other one (referring to the surgical mask) though. V6 then proceeded to open the (closed) double doors and entered the quarantined area without an N95 mask on. On [DATE] at 2:10pm, R7 was observed ambulating throughout the 4th floor hallway without wearing a mask. Surveyor inquired why R7 was in the hallway without a mask on V5 stated He just walked outta his room and he ain't gonna put it on anyway. When somebody ask him, he say no and provided no redirection and/or mask to R7. R8 subsequently exited the elevator with V7 (LPN/Licensed Practical Nurse) however R8's mask was on her chin. Surveyor inquired about the location of R8's mask V7 stated We encourage them (residents) as much as possible to keep em on and provided no redirection to R8. R9 was subsequently observed in the hallway without wearing a mask. Surveyor inquired why R9 was in the hallway without a mask on V8 (LPN) stated She's had one on 4 times. She keeps taking it off, that's what she does and provided no redirection and/or mask to R9. On [DATE] at 2:26pm, 3 residents were observed in the 4th floor dining room not wearing masks. Surveyor inquired about infection control concerns with the residents currently in the dining room V4 (Infection Control Nurse) stated They're not masked. Surveyor inquired about required PPE for residents while not in their rooms V4 responded They need to keep their mask on but nobody up here is going to keep their mask on. Surveyor inquired why none of the 3 residents (currently in the dining room) have a mask available V4 replied We constantly offer them masks however masks were not provided to said residents at this time. On [DATE] at 2:28pm, surveyor inquired if anyone posted contact/droplet precaution signs on and/or near the door of rooms [ROOM NUMBERS] (as warranted) V4 inspected both rooms and stated No, we did not. On [DATE] at 2:30pm, a Doffing Station sign was observed on the (4th floor hallway) wall with 2 red bins below it however the designated area was (outside) the closed double doors (quarantined area). Surveyor inquired where staff are required to doff PPE V4 stated We enter one way and exit the other (referring to the quarantined area), they are supposed to be doing it here in the soiled utility room. Surveyor inquired about the location of the doffing station and red bins V4 responded They're supposed to be back there (referring to the soiled utility room) however the soiled utility room was also located outside the quarantined area. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 2:33pm, a sign stating Please practice social distancing, maintain 6 feet from others was posted (outside the elevator) however V4 entered the elevator with 2 people already in it and stood approximately 2 feet away from them. Surveyor inquired how many people are allowed in the elevator if maintaining 6 feet social distancing V4 stated It's 3 people that's allowed for the building. On [DATE] at 2:36pm, surveyor inquired where (3rd floor) staff doff PPE V10 (LPN) stated You go in (referring to the quarantined area) with your PPE on and there's a doffing over there (referring to the hallway outside the plastic sheets/quarantined area). Surveyor inquired about infection control concerns with the location of the 3rd floor doffing station V10 replied It's in the hallway and affirmed it was outside the quarantined area. On [DATE] at 2:44pm, surveyor inquired about the location of (2nd floor) Covid positive residents V9 stated I believe it's certain rooms in the back and front units and affirmed there was no specific quarantined area on 2nd floor due to recent outbreak. [The [DATE] log of current Covid positive residents includes twelve 2nd floor rooms throughout the unit]. Surveyor inquired where (2nd floor) staff doff PPE V9 responded The doffing station is over there (referring to 2 red bins located in the hallway near room [ROOM NUMBER]). Surveyor inquired about infection control concerns with the location of the 2nd floor doffing station V9 replied We're coming outside in the hall however the contact precaution signs posted on quarantined residents doors state Discard gown before room exit. R4's diagnoses include Covid 19 ([DATE]). R4's ([DATE]) care plan states resident has confirmed Covid 19 infection, intervention: Place in private room or cohort with resident with same symptoms/Covid 19 confirmation. The census affirms that R3 has resided in current room since [DATE]. R4 was moved to R3's room on [DATE] [2 days after confirmed Covid 19 infection]. R4's ([DATE]) care plan states resident has confirmed Covid 19 infection, intervention: follow policy & procedure for contact and droplet precautions. Place in private room or cohort with resident with same symptoms/Covid 19 confirmation however he was placed in R3's room. The census affirms that R3 has resided in current room since [DATE]. R4 was moved to R3's room on [DATE] [2 days after confirmed Covid 19 infection]. The Covid 19 resident tracking affirms R3 sustained covid acquired in facility date of symptom onset [DATE] [4 days after aforementioned room change]. On [DATE] at 2:51pm, contact/droplet precaution signs were posted on R4's door however the door was wide open. On [DATE] at 3:00pm, contact/droplet precaution signs were posted on R5's door however the door was wide open. On [DATE] at 3:12pm, a sign posted (inside the elevator) stated attention use of the elevator is limited to 3 people however there were 4 people observed inside the elevator. Surveyor inquired how many people are allowed on the elevator V11 (CNA) stated 3. On [DATE] at 2:00pm, V1 (Administrator) presented the facility elevator measurements; length: 7 feet, width: 5 feet 6 inches, (continued on next page)

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	145661	A. Building B. Wing	01/26/2022

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Ryze West	5130 West Jackson Boulevard Chicago, IL 60644

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F 0880 Level of Harm - Actual harm Residents Affected - Few	diagonal: 8 feet 9 inches. Surveyor inquired if 3 people are allowed in the elevators V1 stated Right now were allowing 2 diagonally in the elevator. On [DATE] at 12:50pm, surveyor inquired if Covid positive residents room doors are supposed to be open or closed V4 (Infection Control Nurse) stated closed. Surveyor inquired when the Covid outbreak started V4 responded The 1st case we got was [DATE] (2021). Surveyor inquired how many people tested positive for Covid 19 V4 replied Almost everyone 166 residents and 51 staff. On [DATE] at 12:56pm V4 stated, R3 (he) came back yesterday (from the hospital). There was an incident initially ([DATE]) when we were trying to move (R3) because he wasn't covid positive his roommate was. He (R3) declined movement, said no that was his room, and didn't want to move. I (V4) have to look back over the notes because I got like 56 (covid +) residents at one time (,d+[DATE]). The next day 42. Almost everyone 166 residents and 51 staff. We have like 4 people (staff) out (off) still. (R3) became positive I think on the 4th (from [DATE] test). He requested a rapid and it came back negative. R4 was positive [DATE]. R3 it was collected on [DATE] we got results [DATE]. Surveyor asked why was R4's room not changed? V4 stated, because the whole 2nd floor became the covid unit, that's where most cases were. On [DATE] at 1:41pm surveyor inquired about R3's room assignment V12 (Social Service) stated He's been in that room since basically when he was admitted . Surveyor inquired why R4 was placed in (R3's room) on [DATE]. V12 responded He (R4) was likely positive for Covid 19 that's why he was likely moved. Surveyor inquired why R4 (who was Covid positive) was placed in R3's room V12 replied I believe he (R3) was positive too. Surveyor inquired who was responsible for making room assignments V12 stated We (staff) all worked as a team we put people who were positive together and tried to take people that were negative and put them together. I did talk to some of the residents who refused rooms but we did talk to them educated them about the importance of moving rooms because of the protocols. Surveyor inquired if it was appropriate for R4 to be placed in R3's room on [DATE] knowing that he (R4) was positive for Covid and R3 was asymptomatic V12 replied We can't make them move, it's their right. Surveyor inquired about resident safety V12 replied Safety is important but rights supersede safety. On [DATE] at 2:57pm, surveyor inquired about potential harm if a Covid 19 positive resident is placed in a room with an asymptomatic resident V14 (Medical Director) stated The asymptomatic patient would have the potential risk for exposure and may contract the infection. The coronavirus 2019 policy (revised [DATE]) states facility is focused on containing the spread and mitigating the impact of Coronavirus. Covid 19 is spread from person to person by respiratory droplets between people who are in close contact with one another (about 6 feet). Outbreak definition of Covid 19 (one lab confirmed case of Covid 19). Procedure: while at work, the employee must don a facemask. All employees must wear a mask during their shift to protect residents [N95 is not inclusive]. Facility will follow its policies and procedures developed related to Coronavirus 2019 prevention and management based on State Health Department and or CDC (Centers for Disease Control) Interim guidance. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	2. Based upon record review and interview the facility failed to follow policy & procedures, failed to ensure that assessments were documented accurately, failed to ensure that (R4's) physician orders were transcribed on the MAR (Medication Administration Record), failed to follow physician orders for five of five residents (R1, R3, R4, R5, R6) reviewed for Covid infection and failed to cohort all Covid 19 positive residents, these failures resulted in R3 sustaining a positive Covid 19 test result and hospitalization due to hypoxia/bradycardia. Findings include; On [DATE] and [DATE], IDPH (Illinois Department of Public Health) received allegations that Covid 19 positive residents were placed in rooms with Covid 19 negative residents. The following was identified; R4's diagnoses include Covid 19 ([DATE]). R4's ([DATE]) care plan states resident has confirmed Covid 19 infection, intervention: Place in private room or cohort with resident with same symptoms/Covid 19 confirmation. The census affirms that R3 has resided in current room since [DATE]. R4 was moved to R3's room on [DATE] [2 days after confirmed Covid 19 infection]. The Covid 19 resident tracking affirms R3 sustained covid acquired in facility date of symptom onset [DATE] [4 days after aforementioned room change]. On [DATE] at 1:41pm surveyor inquired about R3's room assignment V12 (Social Service) stated He's been in that room since basically when he was admitted . Surveyor inquired why R4 was placed in (R3's room) on [DATE]. V12 responded He (R4) was likely positive for Covid 19 that's why he was likely moved. Surveyor inquired why R4 (who was Covid positive) was placed in R3's room V12 replied I believe he (R3) was positive too. Surveyor inquired who was responsible for making room assignments V12 stated We (staff) all worked as a team we put people who were positive together and tried to take people that were negative and put them together. I did talk to some of the residents who refused rooms but we did talk to them educated them about the importance of moving rooms because of the protocols. Surveyor inquired if it was appropriate for R4 to be placed in R3's room on [DATE] knowing that he (R4) was positive for Covid and R3 was asymptomatic V12 replied We can't make them move, it's their right. Surveyor inquired about resident safety V12 replied Safety is important but rights supersede safety. On [DATE] at 2:57pm, surveyor inquired about potential harm if a Covid 19 positive resident is placed in a room with an asymptomatic resident V14 (Medical Director) stated The asymptomatic patient would have the potential risk for exposure and may contract the infection. R3's ([DATE]) POS (Physician Order Sheets) state monitor patient with Covid 19 diagnosis or suspected Covid 19 for signs of clinical deterioration, such as rapidly progressive respiratory failure and sepsis for 14 days. If positive call MD (Medical Doctor/NP (Nurse Practitioner). Monitor vital signs (full vitals) every 4 hours for 14 days. Observe for evidence of deterioration. Call MD/NP as indicated. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	R3's vitals summary affirms vital signs were obtained on [DATE] at 3:24pm however they were not documented on [DATE] (7pm and 11pm) and on [DATE] (3am, 7am, and 11am) as ordered therefore roughly 23 hours transpired without an assessment. R3's ([DATE]) 2:08pm progress notes state upon entering the room resident observed wheezing stating I can't breathe. Writer applied oxygen 2 liters per nasal cannula, saturation 87%. Nurse Practitioner called gave order to send resident out 911. Resident admitted for hypoxia related to Covid positive and sinus bradycardia (R3's pulse was 52 at 2pm per vitals summary). R1's progress notes state ([DATE]) Covid test result was positive. R1's ([DATE]) POS states monitor patient with Covid 19 diagnosis or suspected Covid 19 for signs of clinical deterioration, such as rapidly progressive respiratory failure and sepsis. Monitor vital signs (full vitals) every 4 hours for 14 days. Observe for evidence of deterioration. Call medical doctor/nurse practitioner as indicated. The ([DATE]/[DATE]) MARS (Medication Administration Records) affirm that R1's vital signs were last documented on [DATE] at 3:00pm therefore on [DATE] (7:00pm & 11:00pm) and [DATE] (3:00am & 7:00am) vital signs were not documented. R1's vitals summary affirms no additional vital signs were documented. On [DATE] at 11:42am, surveyor inquired about the facility protocol for residents who acquired Covid 19 V2 (DON/Director of Nursing) stated We put in orders for vital signs and the monitoring. Surveyor inquired where vital signs are documented V2 responded They're documented on the MAR (Medication Administration Record) they're also documented in the monitoring tool for like a change in condition. It's under forms, Covid monitoring. Surveyor inquired about the required frequency for Covid monitoring V2 replied Everyone (re: Covid positive residents) should be having it (referring to the electronic Covid 19 monitoring evaluation) every shift. Surveyor requested R1, R3, R4, R5 and R6's Covid 19 monitoring evaluations however nothing was received for R4, R5, and/or R6. R1's ([DATE], [DATE] and [DATE]) evaluations were entered by V2 on [DATE] (a week later) additional entries (for evening and night shifts) were not documented. R3's ([DATE] and [DATE]) Covid 19 monitoring evaluations were entered by V2 on [DATE] (days later) additional entries for night shift were not documented. On [DATE] at 10:52am, V2 affirmed that there were no Covid 19 monitoring evaluations documented for R4, R5 and R6 (prior to inquiry). Surveyor relayed concerns with the assessments V2 documented roughly a week after (R1) expired. V2 replied I know I made a mistake and entered something in there. The Covid 19 tracking log affirms R4 sustained facility acquired Covid 19 on [DATE]. R4's ([DATE]) POS states monitor vital signs (full vitals) every 4 hours for evidence of deterioration for 14 days (end date [DATE]). R4's ([DATE]) MAR was reviewed however every 4 hour vital sign orders were not inclusive. R4's ([DATE]-[DATE]) vital signs summary affirms vital signs were not documented. The Covid 19 tracking log affirms R5 sustained facility acquired Covid 19 on [DATE]. R5's ([DATE]) POS states monitor vital signs (full vitals) every 4 hours. Observe for evidence of deterioration (end date [DATE]). R5's ([DATE]-[DATE]) vital sign documentation includes one (1) entry on [DATE] for pulse, respiration and temperature [blood pressure and oxygen saturation is not inclusive]. No additional entries were documented. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	The Covid 19 resident tracking log affirms R6 sustained facility acquired Covid 19 on [DATE]. R6's ([DATE]) POS states monitor vital signs (full vitals) every 4 hours. Observe for deterioration (end date [DATE]). R6's ([DATE]-[DATE]) vital sign documentation includes one (1) entry on [DATE] for blood pressure, pulse, respiration and temperature [oxygen saturation is not inclusive]. No additional entries were documented. On [DATE] at 12:54pm, surveyor inquired why R6's vital signs were not documented every 4 hours as ordered. V4 (Infection Control Nurse) stated I was just looking back to see what happened because the orders are definitely there. The coronavirus 2019 policy (revised [DATE]) states if patients have been screened and their testing is positive for Covid 19: cohort with another symptomatic/positive patient. Vitals (temperature, heart rate, respirations) and pulse oximetry every 4 hours. Blood pressure every 8 hours. The change in resident's condition (reviewed ,d+[DATE]) states nursing will notify the resident's physician or nurse practitioner when: there is a significant change in the resident's physical, mental or emotional status. It is deemed necessary or appropriate in the best interest of the resident.